Adult Services **Rev. 7/2020**
Request for Services
Pre-Screening/Referral Form

Applicant Name: _____ Date: _____

Address: Street: _____ City: _____
State: _____ Zip Code: _____
County: _____
Date of Birth: _____Age: _____

Diagnosis/Disability: _____
Autism Spectrum Disorder Diagnosis or Pervasive Disability Disorder _____ Yes _____No
Was diagnosis prior to the age of 22? _____Yes _____ No

Is Individual their own guardian? _____Yes _____ No
If No, Guardian(s) Name: _____ Phone: _____
Email: _____

Type of services requested from ICA:
Vocational Assessment Only: _____ Adult Services Program Placement: _____

Is individual receiving Educational Services? _____ Yes _____No
If Yes, LEA: _____
If No, completion/graduation date: _____

Is the individual currently receiving Adult Program Services? _____ Yes _____No
Agency: _____
If No, did the individual receive Adult Program Services in the past? _____ Yes_____ No
Agency/Address: _____
Date(s) attended: _____
Reason for leaving: _____

Is the individual registered for PUNS? _____ Yes _____No
Is the individual Medicaid Waiver eligible? _____ Yes _____No
Does the individual receive:
Home Base Support Services funding? _____ Yes _____No
State of Illinois or Federal Funding? _____ Yes _____No

Waiting list requisition made by/Relationship: _____
Phone: _____Alternate Phone: _____
Email: _____

Place on Adult Service Program waiting list: _____ Yes_____ No

ICA staff member completing request for services: _____
Date: _____